CAREFIRST
Daraprim

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Daraprim.

Patient Information

Patient Name:

Patient Phone: ☐☐☐-☐☐☐-☐☐☐☐

Patient ID:

Patient Group:

Patient DOB: ☐☐/☐☐/☐☐☐☐

Physician Information

Physician Name

Physician Phone: ☐☐☐-☐☐☐-☐☐☐☐

Physician Fax: ☐☐☐-☐☐☐-☐☐☐☐

Physician Addr.:

City, St, Zip:

Drug Name (select from list of drugs shown)

Pyrimethamine Daraprim (pyrimethamine)

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1.	Is the requested drug being prescribed for the treatment of toxoplasmosis?	**Y** ☐	**N** ☐
2.	Is the requested drug being prescribed for a pediatric patient?	**Y** ☐	**N** ☐
3.	Is the requested drug being prescribed for the treatment of congenital toxoplasmosis?	**Y** ☐	**N** ☐
4.	Is the requested drug being prescribed for secondary prophylaxis of toxoplasmosis?	**Y** ☐	**N** ☐
5.	Has the patient experienced an intolerance or has a contraindication to sulfamethoxazole/trimethoprim AND is the requested drug being prescribed for ANY of the following: A) primary prophylaxis of toxoplasmosis, B) Pneumocystis jirovecii pneumonia prophylaxis?	**Y** ☐	**N** ☐
6.	Has the patient had a CD4 cell count less than 200 cells/mm3 within the past 3 months?	**Y** ☐	**N** ☐
7.	Has the patient experienced an intolerance or has a contraindication to sulfamethoxazole/trimethoprim AND is the requested drug being prescribed for the treatment of cystoisosporiasis?	**Y** ☐	**N** ☐
8.	Has the patient experienced an intolerance or has a contraindication to sulfamethoxazole/trimethoprim AND is the requested drug being prescribed for secondary prophylaxis of cystoisosporiasis?	**Y** ☐	**N** ☐
9.	Has the patient had a CD4 cell count less than 200 cells/mm3 within the past 6 months?	**Y** ☐	**N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date

Now you can get responses to drug PAs immediately and securely online—without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.